



State or Federal Issues Contacts: Please refer to the list of State Relations Executives at the end of this report.

LEGISLATIVE ACTIVITY—LEGISLATIVE SESSION UPDATES

This report contains descriptions and/or excerpts of relevant bills that passed the first chamber, passed the second chamber, or were enacted during the specific periods. In addition, a recap of significant legislative and judicial activity impacting the workers compensation system will be included in the first report published each month. This report is issued on a weekly basis throughout the legislative season, and it provides updates on the content of these bills if and when they progress through the legislative process. This report includes bills from states where NCCI provides ratemaking services (see state list under Contact Information) and the US Congress.

BILLS ENACTED

The following workers compensation-related bills were enacted within the one-week period ending June 23, 2017.

Florida

HB 837 was:

- Passed by the first chamber on April 26, 2017
- Included in NCCI's May 5, 2017 **Legislative Activity Report** (RLA-2017-17)
- Passed by the second chamber on May 3, 2017
- Included in NCCI's May 12, 2017 **Legislative Activity Report** (RLA-2017-18)
- Enacted on June 23, 2017, with an effective date of July 1, 2017

HB 837, in part, amends **sections 631.021 Jurisdiction of delinquency proceeding; venue; change of venue; exclusiveness of remedy; appeal, 631.191 Special deposit claims and secured claims and 631.397 Use of certain marshaled assets** of the Florida Statutes as follows:

631.021 Jurisdiction of delinquency proceeding; venue; change of venue; exclusiveness of remedy; appeal; construction

- (1) The circuit court shall have original jurisdiction of any delinquency proceeding under this chapter, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this chapter. Any delinquency proceeding in this chapter is in equity.
- (2) The venue of a delinquency proceeding or summary proceeding against a domestic, foreign, or alien insurer shall be in the Circuit Court of Leon County.
- (3) A delinquency proceeding pursuant to this chapter constitutes the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer. ~~A No court may not shall~~ entertain a petition for the commencement of such a proceeding unless the petition has been filed in the name of the state on the relation of the department. The Florida Insurance Guaranty Association, Incorporated, the Florida Workers' Compensation Insurance Guaranty Association, Incorporated, the Florida Health Maintenance Organization Consumer Assistance Plan, and the Florida Life and Health Guaranty Association, Incorporated, shall be given reasonable written notice by the department of all hearings ~~that which~~ pertain to an adjudication of insolvency of a member insurer.
- (4) An appeal shall lie to the District Court of Appeal, First District, from an order granting or refusing rehabilitation, liquidation, or conservation and from every order in a delinquency proceeding having the character of a final order as to the particular portion of the proceeding embraced therein.
- (5) No service of process against the department in its capacity as receiver shall be effective unless served upon a person designated by the receiver and filed with the circuit court having jurisdiction over the delinquency proceeding. The designated person shall refuse to accept service if acceptance would violate a stay against legal proceedings involving an insurer that is the subject of delinquency proceedings or would violate any orders of the circuit court governing a delinquency proceeding. The person denied service may petition the circuit court having jurisdiction over the delinquency proceeding for relief from the

receiver's refusal to accept service. This subsection shall be strictly construed, and any purported service on the receiver or the department that is not in accordance with this subsection shall be null and void.

(6) The domiciliary court acquiring jurisdiction over persons subject to this chapter may exercise exclusive jurisdiction to the exclusion of all other courts, except as limited by the provisions of this chapter. Upon the issuance of an order of conservation, rehabilitation, or liquidation, the Circuit Court of Leon County ~~has shall have~~ exclusive jurisdiction over all with respect to assets or property of the any insurer, wherever located, including property located outside the territorial limits of the state subject to such proceedings and claims against said insurer's assets or property.

(7) This chapter constitutes this state's insurer receivership laws, and these laws must be construed as consistent with each other. If there is a conflict between this chapter and any other law, this chapter prevails.

631.191 Special deposit claims; ~~and~~ secured claims; administration of workers' compensation large deductible policies and insured collateral

(1) Special Deposit Claims The owners of special deposit claims against an insurer against which a liquidation order has been entered in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(2) Secured Claims

(a) The owner of a secured claim against an insurer against which a liquidation order has been entered in this or any other state may surrender her or his security and file her or his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter, or if it has been adjudicated by a court of competent jurisdiction in a proceeding in which the domiciliary receiver has had notice and an opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

(b) The value of any security held by a secured creditor shall be determined under supervision of the court by:

1. Converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditor; or
2. If no such agreement exists, the court shall determine the value in the event the creditor and the receiver cannot agree upon same.

(3) Administration of Workers' Compensation Large Deductible Policies and Insured Collateral

(a) Definitions.—As used in this subsection, the term:

1. "Collateral" means cash, a letter of credit, a surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured's obligation under a large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured's obligation to reimburse or pay the insurer as may be required for other secured obligations.

2. "Deductible claim" means any claim that is within the deductible under a large deductible policy, including a claim for loss and defense and cost containment expense, unless such expense is excluded by the terms of the policy.

3.a. "Large deductible policy" means a combination of one or more workers' compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer, in which the insured has agreed with the insurer to:

(I) Pay directly the initial portion of any claim under the policy up to a specified dollar amount or the expenses related to any claim;
or

(II) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

b. The term also includes policies that contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. A policy must meet the current guidelines for large deductible workers' compensation filings as defined by the office, including the eligibility standards regarding the minimum standard premium and the minimum deductible to be deemed a large deductible policy.

c. The term does not include policies, endorsements, or agreements providing that the initial portion of any covered claim must be self-insured and that the insurer has no payment obligation within the self-insured retention.

d. The term does not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations.

4. "Other secured obligations" means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations, the performance of which is secured by collateral that also secures an insured's obligations under a large deductible policy.

(b) Applicability.—

1. This subsection applies to workers' compensation large deductible policies issued by an insurer that is subject to delinquency proceedings under this chapter. This subsection does not apply to first-party claims, or to covered claims funded by a guaranty association above the deductible unless paragraph (c) applies. Large deductible policies must be administered in accordance with the terms of the policy, except to the extent such terms conflict with this subsection.

2. This subsection applies to all delinquency proceedings that commence on or after July 1, 2017.

(c) Handling of large deductible claims.—Unless otherwise agreed to by the responsible guaranty association, all large deductible claims that are also covered claims as defined by an applicable guaranty association law, including those that may have been funded by an insured before liquidation, must be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund or otherwise, the insured's funding or payment of a deductible claim extinguishes the obligations, if any, of the receiver and any guaranty association to pay such claim. A charge may not be made against the receiver or a guaranty association on the basis of an insured's funding or payment of a deductible claim.

(d) Deductible claims paid by a guaranty association.—

1. To the extent a guaranty association pays any deductible claim for which an insurer would have been entitled to reimbursement from an insured, a guaranty association is entitled to the amount of reimbursements received or collateral available, subject to paragraph (g). Reimbursements paid to the guaranty association pursuant to this paragraph may not be treated as distributions under s. 631.271 or as early access payments under s. 631.397(1).

2. To the extent that a guaranty association pays a deductible claim that is not reimbursed from collateral or by insured payments, or the guaranty association incurred expenses in connection with large deductible policies that are not reimbursed under this subsection, the guaranty association is entitled to assert a claim for those amounts in the delinquency proceeding.

3. This paragraph does not limit any right of the receiver or a guaranty association which may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association's related expenses.

(e) Collections.—

1. The receiver may collect reimbursements owed for deductible claims as provided in this paragraph, and must use reasonable efforts to collect such reimbursements from the insured or the party that is obligated to pay the deductible as specified in the large deductible policy or other agreement. The receiver may bill insureds and others for reimbursement of deductible claims that are:

a. Paid by the insurer before the commencement of delinquency proceedings;

b. Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

c. Paid or allowed by the receiver.

2. If the insured or other party does not make payment within the time specified in the large deductible policy, or, if no time is specified, within a reasonable time after the date of billing, the receiver may take reasonable steps to collect any reimbursements owed.

3. The insolvency of the insurer or its inability to perform any of its obligations under the large deductible policy may not be a defense to the insured's reimbursement obligation under the large deductible policy.

4. An allegation of improper handling or payment of a deductible claim by the receiver or a guaranty association may not be a defense to the insured's reimbursement obligations under the large deductible policy.

(f) Collateral.—

1. Subject to this paragraph, the receiver shall use collateral, when available, to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or payment obligations. A guaranty association is entitled to collateral as provided for in this paragraph to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any distributions made to a guaranty association pursuant to this paragraph may not be treated as distributions under s. 631.271 or as early access payments under s. 631.397(1).

2. The receiver shall draw down collateral to the extent necessary in the event the insured fails to:

a. Perform its funding or payment obligations under any large deductible policy;

b. Pay deductible claim reimbursements within the time specified in the large deductible policy, or, if no time is specified, within 60 days after the date of the billing;

c. Pay amounts due to the estate for preliquidation obligations;

d. Timely fund any other secured obligation; or

e. Timely pay expenses.

3. Claims that are validly asserted against the collateral must be satisfied in the order in which such claims are received by the receiver. However, if more than one creditor has a valid claim against the same collateral and the available collateral, along with billing collection efforts and to the extent that the collateral is subject to other known secured obligations, are together insufficient to pay each creditor in full, the receiver may prorate payments based on the ratio of the amount of claims each creditor has to the total claims paid by all such creditors.

4. Excess collateral may be returned to the insured, as determined by the receiver, after a periodic review of claims paid, outstanding case reserves, and a factor for claims that were incurred but not reported.

(g) Receiver's expenses.—The receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to s. 631.271.

(h) Construction.—This subsection does not limit or adversely affect any rights or powers a guaranty association may have under applicable state law to obtain reimbursement from certain classes of policyholders for claims payments made by the guaranty association under policies of the insolvent insurer, or for related expenses the guaranty association incurs.

631.397 Use of certain marshaled assets

(1) ~~Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state,~~ The department, as receiver, ~~may shall~~ apply to the court for approval of a proposal to disburse assets out of such insurer's marshaled assets, as such assets become available, to each association entitled thereto or, if there are no assets available for such disbursement, then for approval of such proposal as the receiver deems appropriate. For the purposes of this section, the term "association" includes the Florida Insurance Guaranty Association, Incorporated, the Florida Workers' Compensation Insurance Guaranty Association, and any entity or person performing a function in another state similar to that performed in this state by the Florida Insurance Guaranty Association, Incorporated, or the Florida Workers' Compensation Insurance Guaranty Association, provided the Florida Insurance Guaranty Association, Incorporated, or the Florida Workers' Compensation Insurance Guaranty Association, is entitled to like payment under the laws of the association's state of domicile in respect to insolvent companies doing business in that state.

...

~~(4) Notice of such application shall be given by the department to the associations in, and to the commissioners of insurance of, each of the states to which disbursement may be made. Such notice shall be made by certified mail, first-class postage prepaid, at least 15 days prior to submission of such application to the court. Such notice shall be deemed to have been made when deposited in the mail.~~

~~(5) Action on the application may be taken by the court if notice has been given pursuant to subsection (4) and the department's proposal complies with subsection (2).~~

Louisiana

SB 121 was:

- Passed by the first chamber on May 15, 2017
- Included in NCCI's May 26, 2017 *Legislative Activity Report* (RLA-2017-20)
- Amended and passed by the second chamber on June 5, 2017
- Included in NCCI's June 16, 2017 *Legislative Activity Report* (RLA-2017-23)
- Enacted and effective on June 23, 2017

SB 121, in part, amends numerous sections of Title 23, Chapter 10 Labor and Worker's Compensation of the Louisiana Revised Statutes as follows:

§ 1123. Disputes as to condition or capacity to work; additional medical opinion regarding an examination under supervision of the director

If any dispute arises as to the condition of the employee, or the employee's capacity to work, the director, upon application of any party, shall order an additional medical opinion regarding an examination of the employee to be made by a medical practitioner selected and appointed by the director. The medical examiner shall report his conclusions from the examination to the director and to the parties and such report shall be prima facie evidence of the facts therein stated in any subsequent proceedings under this Chapter.

§ 1124. Refusal to submit to an additional medical opinion regarding an examination; effect on right to compensation

If the employee refuses to submit himself to an additional medical opinion regarding a medical examination at the behest of the employer or an examination conducted pursuant to R.S. 23:1123, or in anywise obstructs the same, his right to compensation and to take or prosecute any further proceedings under this Chapter may be suspended by the employer or payor until the examination takes place. Such suspension of benefits by the employer or payor shall be made in accordance with the provisions of R.S. 23:1201.1(A)(4) and (5). When the employee has filed a disputed claim, the employer or payor may move for an order to compel the employee to appear for an additional medical opinion regarding an examination. The employee shall receive at least fourteen days written notice prior to the additional medical opinion regarding an examination. When a right to compensation is suspended no compensation shall be payable in respect to the period of suspension.

§ 1203. Duty to furnish medical and vocational rehabilitation expenses; prosthetic devices; other expenses

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E. Upon the first request for authorization pursuant to R.S. 23:1142(B)(1), for a claimant's medical care, service, or treatment, the payor, as defined in R.S. 23:1142(A)(1), shall communicate to the claimant information, in plain language, regarding the procedure

for requesting an ~~independent~~ additional medical opinion regarding a medical examination in the event a dispute arises as to the condition of the employee or the employee's capacity to work, and the procedure for appealing the denial of medical treatment to the medical director as provided in R.S. 23:1203.1. A payor shall not deny medical care, service, or treatment to a claimant unless the payor can document a reasonable and diligent effort in communicating such information. A payor who denies medical care, service, or treatment without making such an effort may be fined an amount not to exceed five hundred dollars or the cost of the medical care, service, or treatment, whichever is more.

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§ 1221. Temporary total disability; permanent total disability; supplemental earnings benefits; permanent partial disability; schedule of payments

Compensation shall be paid under this Chapter in accordance with the following schedule of payments:

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(4) Permanent partial disability. In the following cases, compensation shall be solely for anatomical loss of use or amputation and shall be as follows:

...

(s)

...

(ii) In any claim for an injury, it must be established by clear and convincing evidence that the employee suffers an injury and that such resulted from an accident arising out of and in the course and scope of his employment. Nothing herein shall limit the right of any party to obtain a second medical opinion or, in appropriate cases, the opinion of an ~~independent~~ additional medical opinion medical examiner pursuant to R.S. 23:1123.

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§ 1307. Information to injured employee

Upon receipt of notice of injury from the employer or other indication of an injury reportable under R.S. 23:1306, the office shall mail immediately to the injured employee and employer a brochure which sets forth in clear understandable language a summary statement of the rights, benefits, and obligations of employers and employees under this Chapter, together with an explanation of the operations of the office, and shall invite the employer and employee to seek the advice of the office with reference to any question or dispute which the employee has concerning the injury. Such brochure shall specifically state the procedure for requesting an ~~independent~~ additional medical opinion regarding a medical examination in the event a dispute arises as to the condition of the employee or the employee's capacity to work and the procedure for appealing the denial of medical treatment to the medical director as provided in R.S. 23:1203.1. If such brochure has previously been mailed to an employer within the calendar year, the office shall not mail ~~such~~ the employer an additional brochure unless the employer specifically requests ~~it~~ such.

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§ 1317.1. ~~Independent~~ Additional medical opinion regarding medical examinations

A. Any party wishing to request an ~~independent~~ additional medical opinion regarding a medical examination of the claimant pursuant to R.S. 23:1123 and 1124.1 shall be required to make its request at or prior to the pretrial conference. Requests for ~~independent~~ additional medical opinions regarding medical examinations made after that time shall be denied except for good cause or if it is found to be in the best interest of justice to order such examination.

B. An examiner performing ~~independent~~ additional medical opinion exams pursuant to R.S. 23:1123 shall be required to prepare and send to the office a certified report of the examination within thirty days after its occurrence.

C. The report of the examination shall contain the following, when applicable:

(1) A statement of the medical and legal issues the examiner was asked to address.

(2) A detailed summary of the basis of the examiner's opinion, including but not limited to a listing of reports or documents reviewed in formulating that opinion.

(3) The medical treatment and physical rehabilitative procedures which have already been rendered and the treatment, if any, which the examiner recommends for the future, together with reasons for the recommendation.

(4) Any other conclusions required by the scope of the ~~independent~~ additional medical opinion regarding a medical examination, together with reasons for the conclusion reached.

(5) A curriculum vitae of the examiner.

(6) A written certification personally signed by the examiner that the report is true. The substance of the certification shall be: "I certify that I have caused this report to be prepared, I have examined it, and to the best of my knowledge and belief, all statements contained herein are true, accurate, and complete."

D. If a physical examination of the claimant was conducted, the certified report shall contain all of the following additional information:

(1) A complete history of the claimant, including all previous relevant or contributory injuries with a detailed description of the present injury.

(2) The complaints of the claimant.
 (3) A complete listing of tests and diagnostic procedures conducted during the course of the examination.
 (4) The examiner's findings on examination, including but not limited to a description of the examination and any diagnostic tests and X-rays.
 E. When the ~~independent~~ additional medical opinion medical examiner's report is presented within thirty days as provided in this Section:
 (1) The examiner shall be protected from subpoena except for a single trial deposition. However, upon a proper motion for cause, the workers' compensation judge may order further discovery of the ~~independent~~ additional medical opinion by a medical examiner as deemed appropriate.
 (2) Except to schedule the deposition or further discovery as described above, the office of the ~~independent~~ additional medical opinion medical examiner shall not be contacted regarding the claimant by any party, attorney, or agent.
 F. Objections to the ~~independent~~ additional medical opinion regarding a medical examination shall be made on form LDOL-WC-1008, and shall be set for hearing before a workers' compensation judge within thirty days of receipt. No mediation shall be scheduled on disputes arising under this Section.

BILLS PASSING SECOND CHAMBER

There were no relevant workers compensation-related bills that passed the second chamber within the one-week period ending June 23, 2017.

BILLS PASSING FIRST CHAMBER

There were no relevant workers compensation-related bills that passed the first chamber within the one-week period ending June 23, 2017.

Contact Information

If you have any questions about the legislation or proposals mentioned, please contact the appropriate NCCI state relations executive (listed below) or a representative of your local insurance trade association.

State	State Relations Executive	Phone Number
CT, ME, NH, RI, VT	Laura Backus Hall	802-454-1800
FL, ID, MT, NV, OR	Peter Burton	610-964-8852
AL, GA, KY, LA, MS	Laura Hart Bryan	225-618-8168
AK, AZ, CO, NM, UT	Maggie Karpuk	818-707-8374
DC, MD, VA, WV	David Benedict	804-380-3005
HI	Carolyn Pearl	808-524-6239
IN, NC, SC, TN	Amy Quinn	803-356-0851
AR, IL, KS, TX	Terri Robinson	501-333-2835
IA, MO, NE, OK, SD	Carla Townsend	314-843-4001
Federal Issues	Tim Tucker	202-403-8526

This report is informational and is not intended to provide an interpretation of state and federal legislation.